

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. Has there been any change in your general health within the past year?
Please specify _____ Yes No
2. Are you under the care of a physician for a current problem?
Reason _____ Yes No
3. Have you been hospitalized with the past five years?
Reason _____ Yes No
4. Are you taking any medications or drugs?
Please specify _____ Yes No
5. Have you received therapy for alcoholism or drug addiction during the past five years? Yes No
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, or other medications?
Please specify _____ Yes No
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma? Yes No
8. Have you ever required a blood transfusion?
Please explain _____ Yes No
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition? Yes No
10. Have you ever been tested for HIV infection (AIDS)?
Result of test: Positive Negative Date _____ Yes No
11. Date of last physical exam _____
12. Do you have or have you had any of the following (please check):

<input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart murmur of prolapsed valve (MVP) <input type="checkbox"/> Joint prosthesis (hip, knee, etc.) <input type="checkbox"/> Rheumatic fever or rheumatic heart disease <input type="checkbox"/> Congenital heart disease <input type="checkbox"/> Cardiovascular disease: heart attack, stroke, by-pass <input type="checkbox"/> Prosthetic heart valve <input type="checkbox"/> Blood disorder (e.g., anemia) <input type="checkbox"/> Venereal disease <input type="checkbox"/> Asthma <input type="checkbox"/> Temporomandibular joint problems (TMJ)	<input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes <input type="checkbox"/> Stomach ulcers, colitis <input type="checkbox"/> Hepatitis, jaundice, liver disease <input type="checkbox"/> Kidney problems <input type="checkbox"/> Psychiatric treatment <input type="checkbox"/> Fainting spells or seizures <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Sinus trouble
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13. Do you have any disease, condition, or problem not listed above?
Please specify _____ Yes No
14. Are you required to take premeds prior to dental treatment? Yes No

Women:

15. Are you pregnant? Yes No
16. Are you nursing? Yes No
17. Do you take birth control pills? Yes No
If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

All of the above information is true to the best of my knowledge.

PERMISSION FOR ROOT CANAL TREATMENT: I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Signature of Patient* _____ Date _____

**All signatures must be by parent or guardian if patient is under the age of 18.*